Claims Payment Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
11201	**Perform EDI Oversight**	The costs related to the establishment of EDI authorizations, monitoring of performance, and support of EDI trading partners to assure effective operation of EDI processes for electronic billing, remittance advice, eligibility query, claims status query, and other purposes; and/or between Medicare and a bank for electronic funds transfer or remittance advice. **Reference:** • Manual, Chap. 2 Section 30.6, 30.6.1, 30.6.230.6.3, 30.6.4, Chap. 24, Section 20.1.1, 20.2, 20.3, 20.4, 20.5, 40.2,40.4,40.4.3,40.5, 50.1, 50.2, 50.3, 50.4, 50.5, 60.1, 60.2, 60.3, 60.8, 60.8.1, 60.8.2, 60.8.3,60.8.4, 70, 70.1	a. Obtain valid EDI and EFT agreements, provider authorizations for third party representation for EDI, and network service agreements. Enter the data into the appropriate provider-specific and security files, and process reported changes involving those agreements and authorizations b. Issue/control/update/monitor passwords and EDI billing/inquiry account numbers c. Sponsor providers and vendors to establish IVANS, other private network, and LU 6.2 connections where supported. d. Systems test with electronic providers/agents to assure compatibility for the successful exchange of data e. Submit EDI data, HIPAA implementation status, and submitter HIPAA testing status reports f. Monitor and analyze recurring EDI submission and receipt errors, and coordinate with the submitters and receivers when necessary to eliminate errors g. Investigate high provider eligibility query to claim ratios and initiate corrective action as needed h. Maintain a list on your web page of software vendors whose EDI software has successfully tested for submission of transactions to Medicare i. Furnish support to providers on the use of the free/low cost billing software j. Furnish basic support to providers on interpretation of transactions issued by Medicare	

Claims Payment Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
11202	**Manage Paper Bills/Claims**	All costs related to the receipt, control, and entry of paper claims and for maintenance of the standard paper remittance advice format This activity encompasses tasks prior to and following the shared system process. **Reference:** • Medicare Claims Processing Manual, Chap 1, Section 40.4.1, 50, 50.1.1, 50.1.8, 50.2, 80, 80.1,80.2.1, 130, 130.1. Chap. 22, Sections 10, 20,30, 50, 50.2, Chap. 24, Sections 40.3.2, 40.4, Chap. 25, Section 50.1,	a. Receive, open, sort and distribute incoming claims b. Assign control numbers and date of receipt c. Image paper claims and attachments d. Perform data entry (whether manual or electronic scanning) e. Identify claims that cannot be processed due to incomplete information f. Resolve field edit errors g. Return incomplete paper claims or paper claims that failed pre-shared system edits to providers for correction and resubmission h. Re-enter corrected/developed paper claims i. Update the standard paper remittance advice format annually	**Workload 1** is the difference between the total claims reported on the HCFA-1565, Page 9, Line 38, Column 1 minus the EMC claims reported in Line 38, Column 6.
11203	**Manage EDI Bills/Claims**	Establish, maintain, and operate the infrastructure for EDI and DDE , as supported, for claims, remittance advice, status query, eligibility query, and EFT. Requires 1 upgrade per year in each of the EDI formats supported, free billing software, and related tasks. **Reference:** • Medicare Claims Processing Manual, Chap. 2, Section 30.6.1, 30.6.1.1, 30.6.1.2, 30.6.1.3, 30.6.1.4, 30.6.1.5, 30.6.2, 30,6.3, 30.6.4, 30.6.5, 30.6.6.	a. Provide free billing software, PC-Print software, and update once per year b. Alpha test and validate the free billing software c. Assist with resolution of problems with telecomm protocols and lines, and your software and hardware to maintain connectivity with partners d. Maintain capability for receipt and issuance of transactions via DDE, where supported, and in batches e. Maintain EDI access, syntax, and semantic edits at the front-end, prior to shared system processing f. Route edit and exception messages, claim acknowledgements, claim development messages, and electronic remittance advice and query response transactions to providers/agents via direct transmission or via deposit to an electronic mailbox for downloading by the trading partners; route EFTs; and receive 997 transactions from trading partners reporting errors in transactions g. Verify the validity of the EDI data received from electronic	**Workload 1** is reported on the HCFA-1565, Page 9, Line 38, Column 6.

Claims Payment Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		• Medicare Claims Processing Manual, Chap 1, Section 40.5, 80.1, 80.2, 80.2.1, Chap 3, Section 10.3,,Chap 24, Section . 30.1. 30.2. 30.3. 30.5, 30.6, 40, 40.1. 40.2, 40.3, 40.3.3, 40.4, 40.4.1, 40.5, 50, 50.1, 50.2, 50.3, 50.4, 50.5, 60.1, 60.5, 60.6, 60.6.2, 70,. 80.1, 80.2, 80.3, Chap. 25, Section 50.1, • Medicare Claims Processing Manual Chap. 25, Section 20, 20.2, 20.3, 20.4, 20.5, Medicare Claims Processing Manual, Chap 24, Section 40, 40.3, 40.3.1, 40.3.3, 60.6, 60.6.1, 60.6.2 Medicare Claims Processing Manual Chap. 24, Section Chap. 28, Section 80, • Medicare Claims Processing Manual Chap. 24, • Medicare Claims Processing Manual Chap. 22, Section 30, 40.1, 40.3, 60.1, • Medicare Claims Processing Manual Chap. 24, Section 70.1, Chap. 28, Section 80.3.1 • Medicare Claims Processing Manual Chap. 25, Section 20.6, • Medicare Claims Processing Manual Chap. 25, Section	trading partners through selective audits and use of other verification tools h. Maintain back-end edits to assure remittance advices and query responses comply with the implementation guide requirements, and EFTs comply with the ACH or 835 requirements i. Create a copy of EDI claims as received and have the ability to recreate each outgoing remittance advice and COB transaction j. Maintain audit trails to document processing of EDI transactions k. Translate transaction data between pre-HIPAA and HIPAA standard formats and the corresponding shared system flat files l. Update claim status and category codes, claim adjustment reason codes, and remittance advice remark codes m. Bill third parties for electronic access to beneficiary eligibility data, maintain receivables for those accounts, and terminate third parties for non-payment	

Claims Payment Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		30.4 • Medicare Claims Processing Manual Chap. 22, Section 60.2, • Medicare Claims Processing Manual Chap. 22, Section 60.1, 60.2, 60.4, Chap. 24, Section 40.3.2, • Medicare Claims Processing Manual Chap. 22, Section 10		
11204	**Bills/Claims Determination**	Most of the costs related to the determination of whether or not to pay a claim after claim entry and initial field edits are automated and captured under the Run Systems activity. However, operational support staff is required to support claims pricing and payment in conjunction with the programming activities included under Run Systems. Costs of these support activities, which include the creation, maintenance, and oversight of reasonable charge screens, fee schedules, and other pricing determination mechanisms that support claims processing systems, are reported under the Bills/Claims Determination activity. Also, the cost of any staff intervention in the adjudication of claims resulting from automated claims payment	a. Maintain fee schedule (local variations) b. Check for duplicates c. Identify claims that have to be resolved manually d. Re-enter corrected/developed claims that suspend from the standard system e. Resolve edits on claims that cannot be processed (if possible) f. Maintain pricing software modules g. Update HCPCS, diagnostic codes, and other code sets that impact pricing as needed	**Workload 1** for adjudicated claims is the difference between the cumulative number of claims processed reported on the HCFA-1565, Page 1, Line 15, Column 1 minus Line 16, Column 1 (replicates).

Claims Payment Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
		edits should be assigned to this activity. **Reference:** •		
11205	**Run Systems**	The costs of procurements and the programmer/management staff time associated with the systems support of claims processing outside those provided by the standard system maintainer under direct contract to CMS. It also includes, but is not limited to: data center costs for Bills/Claims Payment; local CPU costs for claims processing (including those associated with the application of MIP edits); validating new software releases; maintaining interfaces and testing data exchanges with standard systems, CWF, HDC, State Medicaid Agencies; maintaining the Print Mail function, on-line systems, telecommunications systems, and mainframe hardware; providing LAN/WAN support; and ongoing costs of transmitting claims data to and from the CWF host, as well as other telecommunications costs. **Reference:** •	a. Test releases b. Assign Data Center costs c. Purchase software/hardware d. Generate data for MSNs/EOMBs/NOUs, paper remittance advices, and paper checks *(Note: any associated printing and mailing costs will be included in the "Manage Outgoing Mail" activity*) e. Manage change requests	

Claims Payment Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
11206	**Manage IS Security Program**	The costs necessary to adhere to the CMS information systems security policies, procedures and core security requirements, re: the CMS Business Partner Systems Security Manual (BPSSM). **Reference:** • BPSSM Section 2.2 • BPSSM Section 3.1 • BPSSM Section 3.2 • BPSSM Section 3.3 • BPSSM Section 3.4 • BPSSM Section 3.5.1 • BPSSM Section 3.5.2 • BPSSM Section 3.6 • BPSSM Section 3.7 • BPSSM Section 3.8	a. Principal Systems Security Officer (PSSO) staffing (including support staff), and training and supporting PSSO functions and responsibilities (Section 2 of the BPSSM) b. Conduct an annual self-assessment using CAST (A-2 of the BPSSM) c. Develop, review and update the systems security plans (Section 3.1 of the BPSSM) d. Conduct, review and update the Information System Risk Assessment (Section 3.2 of the BPSSM) e. Prepare the annual systems security component of internal control certification (Section 3.3 of the BPSSM) f. Prepare, review, update and test the information technology systems contingency plan (Section 3.4 of the BPSSM) g. Conduct an Annual Compliance Audit and implement Corrective Action Plans to resolve resultant findings (Section 3.5 of the BPSSM) h. Develop Computer Incident Reporting and Response Procedures (Section 3.6 of the BPSSM) i. Develop and maintain a system security profile (Section 3.7 of the BPSSM)	
11207	**Manage TPAs to Accomplish Coordination of Benefits with Supplemental Payers and States**	The costs associated with the solicitation and execution of agreements for the purpose of crossing paid claims data to health care insurers; continuation of activities related to the cross over Medicare paid claims data to new and existing trading partners; and collection of fees. **Reference:** • Medicare Claims Processing Manual Chap. 28, Section 70, 70.1PM AB-02-095 • PM AB-03-066	a. Market, execute and maintain CMS's Standard Trading Partner Agreement (TPAs) for COB purposes b. Perform billing/collections functions for crossover activities to ensure that electronic Medigap insurers and electronic non-Medigap (i.e., complementary) insurers, as well as paper Medigap insurers, are charged the appropriate rates established by CMS c. Perform internal and external systems support and testing d. Maintain information to answer inquiries regarding crossover claims e. Resolve problems with trading partners and impacted providers f. Resolve COB processing problems (e.g., in matching data and transmitting files)	**Workload 1** is the number of claims transferred as designated in the MCM 4361.10. (Currently only reported on the FACP). **Workload 2** is the number of TPAs executed in this fiscal year.

Claims Payment Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
11208	**Conduct Quality Assurance**	The costs related to routine quality control techniques used to measure the competency and performance of claims processing personnel; quality assurance reviews of fee schedules, HCPCS and ICD-9 updates and maintenance; and review of contractor systems. **Reference:** • MCM, Part 1, Section 4213 • MCM, Part 2, Chapter 3, Section 5240 • MCM, Part 3, Sections 7032.3 • MCM, Part 3; Section 13360.1 • MCM, Part 3, Section 14002 • MCM, Part 3, Section 15023	a. Review suspended/reopened claims for correct processing b. Review processed paper/EMC claims for accuracy c. Perform other QC sampling techniques for claims processing d. Perform QA on fee schedules maintenance and contractor systems	
11209	**Manage Outgoing Mail**	The costs to manage the outgoing mail operations for the bills/claims processing function (e.g., costs for postage, printing NOUs/MSNs/EOMBs, remittance advices and checks, and paper stock). **Reference:** • Medicare Claims Processing Manual, Chap 1, Section 20 • Medicare Claims Processing Manual Chap. 22, Section 10,.	a. Mail NOUs/MSNs/ EOMBs, paper remittance advices, and checks b. Mail requests for information (other than medical records or MSP) to complete claims adjudication c. Return unprocessable claims to providers d. Return misdirected claims e. Forward misdirected mail	

Claims Payment Carrier Activity Dictionary

CAFM Code	Activity Name	Definition	Tasks	Workload
11210	**Reopen Bills/Claims**	The costs related to the post-adjudicative reevaluation of an initial or revised claim determination in response to (e.g.) the addition of new and material evidence not readily available at the time of determination; the determination of fraud; the identification of a math or computational error, inaccurate coding, input error, misapplication of reasonable charge profiles and screens, etc. **Reference:** •	a. Receive written inquiry or referral for reopening b. Control and image claim c. Research validity of issues related to the reopening d. Adjust claim as appropriate e. Issue response related to claims determination if necessary (e.g., a revised NOU or EOMB) f. Refer to other areas if appropriate to the circumstances g. Document and maintain files for appropriate retrieval	
11211	**Non-MSP Carrier Debt Collection/ Referral**	The costs incurred in the recovery of all Part B Program Management overpayments by carriers in accordance with applicable laws and regulations. *(Note: the costs of developing an overpayment should be captured in the respective budget area from which it was generated).* **Reference:** • Medicare Financial Management Manual, Chapter 3 & 4	a. Initiate the prompt suspension of payments to providers to assure proper recovery of program overpayment and reduce the risk of uncollectible accounts b. Verify bankruptcy information for accuracy and timeliness c. Coordinate with CMS/OGC and update the PSOR to ensure proper treatment and collection of overpayments d. Refer eligible debt to Treasury e. Review all extended repayment plan requests (ERPs) f. Coordinate with CMS on ERPs	